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12-10-2004

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Bulling, Denise, "Nebraska Hospital Preparedness for Psychological Consequences of Public Health Emergencies (Survey Results Summary)" (2004). *Publications of the University of Nebraska Public Policy Center*. 19.

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Nebraska Hospital Preparedness for Psychological Consequences of Public Health Emergencies

Survey Results Summary

The University of Nebraska Public Policy Center recently surveyed hospitals across Nebraska to evaluate behavioral health readiness in the event of a disaster, act of terrorism (including bioterrorism) or other mass-casualty incident. The survey also asked about hospitals' ability to effectively coordinate with other emergency service providers, such as law enforcement, in the event of a critical incident.

Behavioral health readiness refers to a hospital's capacity to effectively manage and respond to the psychological needs of patients, staff, and their families resulting from a large scale event or emergency. In many hospitals in Nebraska this capacity is not maintained internally and there is an informal reliance on local mental health resources to handle any psychological surge. The challenge associated with this mechanism is the lack of professional mental health resources in many areas of the State. The U.S. Department of Health and Human Services (2003) designated 88 of Nebraska's 93 counties as Mental Health Professional Shortage Areas.¹ This means that nearly 95% of Nebraska counties are without sufficient mental health services.

Survey Results

Invitations were sent to Emergency or Safety Coordinators of the 90 members in the Nebraska Hospital Association in August 2004 to participate in a web based survey designed to assess the resources hospitals have available to manage the psychological consequences of terrorism or other public health emergency. Respondents included 46 of those members (51%).

Hospital staff must be able to identify psychological casualties following an act of bioterrorism or other public health emergency for psychological surge capacity to be activated. Many hospitals (40%) identified themselves as "somewhat prepared" to identify psychological casualties following an act of bioterrorism or mass casualty event and 48% identified themselves as "not at all prepared" or "not very prepared." This raises questions regarding some hospitals' current ability to successfully triage medical versus psychological casualties.

The survey indicated more than 65% of the hospitals contacted do not have mental health services immediately available after an act of bioterrorism or other public health emergency. Respondents reported that either lack of mental health resources (33%) or limited funding for mental health services (26%) posed significant barriers to their efforts to integrate mental health resources into their disaster-response capabilities.

¹ Fraser, R.F., Hesford, B., Rauncer, T. Health Professional Shortage Areas Nebraska - 2003. Nebraska Health Data Reporter, 5 (1), December 2003.

Respondents also raised additional issues: difficulty coordinating medical and psychiatric resources during a crisis, limited administrative support of mental health, and patients' reluctance to use mental-health resources.

Many hospitals (86%) responded that they have lists of local-area mental health professionals they could contact to assist with crisis-response activities. So while there is a shortage of mental-health professionals, there is a perception that there is adequate access to professionals who may be called on an "as needed" basis. Another response option, telemedicine, was reported as available and relied upon by a number of hospitals.

The professionals that hospitals rely on to provide surge capacity to manage psychological casualties in the emergency room are varied. The vast majority of hospitals (84.1%) reported they would use area clergy and faith leaders as part of the response. In addition 79.5% of respondents indicated they rely on existing hospital staff to provide the service. Social workers (80%) were the most commonly cited professional mental health resource relied upon by hospitals, followed by counselors (48.6%), psychologists (38.6%), and psychiatrists (31.8%). This is not surprising as social workers are more commonly integrated and available within hospital settings.

The trend to rely on existing staff to manage psychological casualties indicates a need for hospital staff to have competencies in psychological crisis intervention and triage. Respondents were asked about the type of training hospital staff had received in the last year. Among existing hospital staff, 59.5% have received no specialized mental-health training. A sizeable minority, 23.8%, have received Critical Incident Stress Management (CISM) training and/or Psychological Crisis Intervention training.

Despite the reported availability of resource lists and access to professionals, the vast majority (from 68%-88%) of the hospitals surveyed did not have a written plan designated to meet the mental health needs of medical staff, patients, volunteers, family members of patients, family members of staff, and administrative staff. Respondents reported that they relied heavily on Critical Incident Stress Management mechanisms, in house peer support, referral to private providers, and Employee Assistance Programs to meet staff needs.

Hospitals generally had plans in place to coordinate with other emergency providers, such as law enforcement. About 80% of respondents reported having a written plan for coordinating with law enforcement after an act of bioterrorism or other public-health emergency. Furthermore, 85% reported that their plan addressed the topic of enhanced physical security at hospitals; 62% reported covering the coordination and access to patient information to investigators; and 58% endorsed reviewing Civil Commitment issues. Finally, 69% addressed the coordination of risk communication (i.e. dissemination of relevant risk-related information to public).

Recommendations

Physicians and nurses are concerned with the psychological well being of those they care for in hospitals every day. They may rely on others within the hospital setting and from the surrounding community to augment their capacity to manage psychological consequences of large events that tax the medical resources of the facility. The results of the survey, including comments made on open ended questions, lead to three recommendations.

1. Hospital response plans for large emergencies should include a section that specifically addresses the management of psychological consequences. Any reported reliance on resources outside the hospital should be enumerated and verified regularly to insure that they can be accessed and coordinated when needed. Consider how these community resources can be more formally linked to the hospitals. Hospitals that rely on telehealth for emergency response should consider augmenting that capacity with on-site personnel (natural helpers from the community or mental health professionals). Reported reliance on internal resources should be accompanied with specific activation and delineation of psychological helping roles that personnel will assume in the emergency. This may include roles for hospital volunteers or support workers. Additionally, plans should address the psychological needs of staff and their families that may result from their role in the response.
2. Exercise the behavioral health portion of the plan along with medical response protocols to emergencies.
3. It is recommended that education in crisis intervention or "psychological first aid" be made available to all personnel working or expected to work in emergency care settings during the response to a large event. This includes registrars, volunteers, and support personnel who may be expected to come in contact with the public during the course of a response. Additional professional education for medical personnel in effective triage of psychological casualties in bioterrorism or mass casualty events should also be made available on a more regular basis.

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